OREGON MEDICAL BOARD
REPORT

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Upcoming Meetings

March 4, 8 a.m.
Investigative Committee

March 10, 5 p.m.
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March 11, 2 p.m.
Workgroup on Sexual Misconduct

April 1-2, 8 a.m.
Board Meeting

Celebrating 50 Years of PA Service in Oregon

The physician assistant profession was created in the mid-1960s to improve and expand health care in the face of a primary care physician shortage. Today, the Board oversees more than 2,500 physician assistants.

1965: Duke University establishes inaugural class of physician assistants with a curriculum based on fast-track medical training during World War II. The first class of PAs graduate in 1967 and are lauded as a creative solution to extend medical care in the face of physician shortages.

1971: PAs become the first group of new licensees to come under the Board's purview.

1980: Dennis Bruneau, PA-C, and Dave Jones, PA-C, become the first PAs in the country allowed to practice remotely from a supervising physician, including independent prescribing and dispensing authority, while serving rural Oregon.

1987: First celebration of National PA Day takes place on October 6, the 20th anniversary of the graduation of the first class of PAs.

2003: PAs are granted the privilege of prescribing and administering Schedule II controlled substances after fulfilling specific educational and certification requirements.

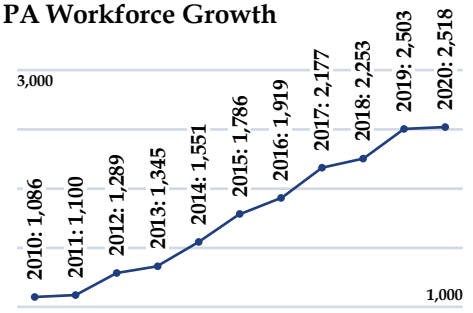
2011: The passage of House Bill 224 leads to sweeping changes in PA regulation, including the separation PA licensure from the establishment of a supervisory relationship with a physician.

2015: House Bill 905 passes, establishing a new PA seat on the Oregon Medical Board.

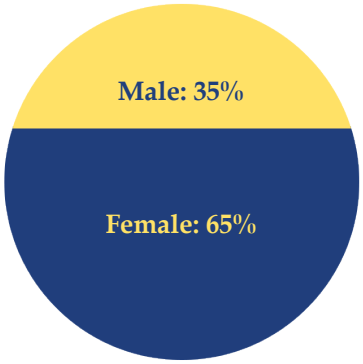
Today: More than 2,500 PAs provide medical care to Oregonians, helping to ensure that patients have access to high-quality care.

PAs by the Numbers

PA Workforce Growth



PAs by Gender (2020)



Geographic Distribution

More than 63% of Oregon's Licensed PAs practice in only five counties: Clackamas, Deschutes, Lane, Multnomah, and Washington.

The mission of the Oregon Medical Board is to protect the health, safety and wellbeing of Oregon citizens by regulating the practice of medicine in a manner that promotes access to quality care.

Understanding COVID-19 Quarantine and Isolation Recommendations

Melissa Sutton, MD, MPH; Ann Thomas, MD, MPH; and Douglas Lyon, MD, MPH | Senior Health Advisors, Oregon Health Authority

It has been 12 months since Oregon announced its first diagnosed case of COVID-19, and we face a difficult winter ahead. But the availability of safe and effective COVID-19 vaccines raises hope for a return to a more normal life by this time next year.

COVID-19 activity has surged dramatically in recent months. As temperatures have cooled, people have moved activities indoors. Variable compliance with masking, distancing, and social gathering recommendations has led to statewide increases in COVID-19 transmission. The huge burden of disease has diminished the ability of state and local public health authorities in Oregon to investigate all cases and reach out to all contacts—an unfortunate scenario currently playing out in most U.S. states and in many other countries. The burden of informing patients regarding isolation and quarantine requirements has increasingly fallen on patients, providers, and health care systems.

Because many health care providers may not be familiar with COVID-19 isolation and quarantine recommendations, we'd like to provide an overview.

Isolation is the term used to describe someone with COVID-19 avoiding contact with others. The CDC and the Oregon Health Authority (OHA) recommend that most patients with COVID-19 isolate for 10 days and until they have been fever-free for 24 hours with symptoms improving. Patients who have been severely ill with COVID-19, such as those who have been hospitalized, or patients who are severely immunocompromised, should isolate for 20 days and until they have been fever-free for 24 hours with symptoms improving. Testing is not recommended as a precondition for release from isolation because patients may continue to shed inactive viral particles (and falsely test positive) after they are no longer contagious to others. For patients with symptoms, the first day of isolation is counted as the day their symptoms began; for patients without symptoms, the first day of isolation is counted as the day that their COVID-19 specimen was obtained.

Quarantine is the term used to describe someone who has had close contact with a case of COVID-19. We define 'close contact' as contact which occurs within six feet for longer than 15 minutes cumulatively in a single day. The first day of quarantine is counted as the last day of exposure to the case of COVID-19. The safest length of quarantine is 14 days because this is the longest possible incubation period for the SARS-CoV-2 virus. However, to improve compliance with quarantine and recognize the significant economic ramifications of prolonged quarantine, the CDC has released new options to reduce the length of quarantine, which may be viewed **here**. According to these new recommendations, people under quarantine may:

- End quarantine at day 10 if they have not developed symptoms; or
- End quarantine at day seven if they have not developed symptoms and have tested negative for COVID-19 by PCR or antigen test on or after day five.

People under quarantine must complete daily symptom monitoring through day 14. The estimated risk of transmitting COVID-19 after quarantine according to these options is 1% (with an upper limit of 10%) at day 10, and 5% (with an upper limit of 12%) at day seven given a negative test. OHA will adopt these recommendations in all settings except outbreaks in congregate care facilities, in which the post-quarantine transmission risk is unacceptably high given the chance of severe illness and death in these vulnerable populations. Ending quarantine at day seven through testing may not be widely available during the surge as testing remains in high demand, and testing should be prioritized for symptomatic patients when shortages occur.

We know that asking providers to educate patients on the need for isolation and quarantine may feel like an enormous task. OHA will soon publish new guidance online to answer frequently asked questions and teach COVID-19 cases how to perform their own contact tracing. You can refer patients to the website or print out information for them. In this unprecedented public health emergency, we need your help. You are all public health ambassadors.

We want to thank you for your service—for continuing to care for your patients and our communities, at risk to yourself and your families. We look forward to a time soon when COVID-19 vaccines are widely available, transmission has diminished, and we can look back and know that we did our best to keep people in Oregon healthy. ✚

From the Desk of the Medical Director

David Farris, MD | Medical Director, Oregon Medical Board

Refusal of vaccines and vaccine hesitancy have always invited dire consequences, but in the face of the current pandemic, vaccine acceptance takes on special urgency. Joel Amundson, MD, a pediatrician in private practice in North Portland, has developed an approach he has found to be effective with patients who are actively questioning vaccination. I asked Dr. Amundson to share his approach with OMB licensees.

The companion piece on the next page is excerpted from **"How to Overcome Covid-19 Vaccine Hesitancy Among Black Patients,"** written by Andis Robeznieks of the AMA and published online on December 19, 2020 (used here with permission). ✚

Vaccine Cognitive Biases

Joel Amundson, MD | Private Practice, Portland, OR

Imagine two scenarios in the next flu season:

A) A patient doesn't get the flu vaccine, then comes down with a bad case of the flu. They take Tamiflu on day three or four, which is too late to be beneficial and only causes side effects. They eventually get well unrelated to the drug.

B) A patient does get the flu vaccine. They catch a milder case of the flu, only getting half as sick as they would have.

Despite being worse for us, our subconscious will favor scenario A because it is started at the peak of illness, while patients revert to wellness. Conversely, people subconsciously dislike vaccines because they are taken at the peak of wellness, right before illnesses and other things are expected to happen.

Before we blame hesitant patients for misplaced instincts, we must bear in mind that this is the way our brains are wired. It's not faulty reasoning, it hasn't gotten to reasoning yet. And that's where we can help. There are effective ways to guide patients through an understanding of cognitive bias before we approach the science of vaccines. When we do this, they want to hear and trust the science. Without this understanding, they will remain skeptical because the science doesn't match their intuition. Making them more afraid of the disease or talking about the science all day will only make this worse because it increases the disparity between their emotion and the science, making them more uncomfortable and afraid. So they postpone.

In a study on vaccine-hesitant parents, even when researchers succeeded at debunking the MMR/autism myth to the parents' satisfaction, it didn't change their intent to vaccinate. Nor did removing all mercury from childhood vaccines after anti-vaccine voices had long blamed it for all vaccine woes - they simply moved on to accuse other vaccine ingredients. Clearly, these myths are merely fleeting faces on which to blame a misunderstood discomfort, NOT the cause of their hesitancy. Until this is brought to light, any other tactic will not help, and may make things worse.

Why don't patients trust us? Imagine a patient experiencing the typical subconscious response noted in the opening example, then being asked to take the next vaccine. Going against an emotion they don't understand makes this a stressful decision. Afraid to make it under pressure, they may look it up online before meeting with you. Most are not doing this to discredit your advice; they're doing it to calm their fears. They want to vaccinate and just want to know it's safe. Unfortunately, what they find are massive amounts of false information tailor-made to capture exactly the feelings they are struggling with. Finally, they have "science" that matches their feelings andthey get trapped down a rabbit hole of false information. They are victims, not perpetrators.

Most of us have not received any training on how to handle this situation using evidence-based techniques. Many physicians have tried tactics such as frightening patients into vaccinating or expelling them from the practice, but these actions are counterproductive. Fortunately, an effective solution exists. Similar to motivational interviewing for smoking cessation, a huge part lies in building rapport and trust, empathizing with their feelings, and finding common goals. And unique to vaccines, if they are not aware of their subconscious bias, logic and data will backfire. We need to address this before science. Here are a few points of particular importance to vaccines, in rough order of application:

1) Be clear about your recommendation. Don't offer a noncommittal "Would you like to do this vaccine?" when it is universally recommended and safe for the particular patient. While you want to be open and willing to work with the patient, lack of clarity will only give them a confusing message about whether it's recommended or not. State the facts: "You are due for this vaccine" and your recommendation: "I recommend this vaccine for you today." By all means follow that with, "Do you have any questions about this vaccine?"

2) Ask questions before debating or refuting. If they bring up reservations, ask what their goals are for their health. Ask about their biggest vaccine worries, and where they received the information. If you don't consider their concern before discrediting it, they will assume you ignore potential problems with vaccines, which makes them not trust you. If you show an avid interest in their concern and, only after doing so, explain that you have actually considered that (including why you're not worried about it), they will feel relieved. E.g., "I can see how that would sound concerning. Can you send me the source for that so I can look into it?" Sometimes, even by giving you the source they realize the ridiculousness as they look down at the ground and mumble "Facebook."

Continued on page 10

How to Overcome Covid-19 Vaccine Hesitancy Among Black Patients

Andis Robeznieks | Senior News Writer, American Medical Association

This article was originally published by the American Medical Association on December 29, 2020, and is excerpted here with permission. Read the article in full here.

To understand and address vaccine hesitancy and the roots of medical mistrust among Black Americans, look to the U.S. Public Health Service Study at Tuskegee—but not as an isolated event. Rather, it's one component of structural racism that requires structural solutions as the nation seeks to speed the pandemic's end.

"This was a structural, deliberate program and an institutional initiative—so any interventions at this point need to demonstrate that same intention and fidelity to structural change," says Giselle Corbie-Smith, MD, a professor of medicine and social medicine at the University of North Carolina (UNC) and director of the UNC Center for Health Equity Research.

According to a Pew Research Center survey conducted Nov. 18-29, 83% of Asian-Americans, 63% of Latinx and 61% of white adults say they will definitely or probably get a COVID-19 vaccine, yet only about 42% of Blacks would do so.

In "Distrust, Race and Research," a landmark 2002 JAMA Internal Medicine study that has been referenced in more than 600 other studies, Dr. Corbie-Smith and colleagues found that, compared with white Americans, African Americans were more likely to believe that physicians would ask them to participate in harmful research, expose them to unnecessary risks, not fully explain the research, or treat them as part of an experiment without their consent.

Tuskegee doesn't stand alone

The infamous Tuskegee study was conducted by the U.S. Public Health Service from 1932 to 1972. Black men who thought they were receiving free health care were instead involved in a study of untreated syphilis without their knowledge or consent.

While it's commonly believed that this is the source of Black mistrust that impedes their participation in clinical trials even now, Dr. Corbie-Smith and her co-authors wrote that "distrust in medicine and research may be rooted in experiences extending back to slavery and continuing to the present day."

The challenge in 2020 is how to overcome this distrust so that African Americans have confidence that getting a COVID-19 vaccine will benefit their health and not worsen it.

Building trust is paramount. Kim Gallon, PhD, Associate Professor of History at Purdue University, states a necessary first step is for predominantly white institutions to trust Black physicians and Black researchers to implement cultural approaches they know will work with Black communities. Dr. Gallon is founder and executive director of COVID Black, a collective and an early response taskforce on Black health that creates digital resources designed to raise awareness about health disparities.

She states, "That's going to mean giving time and resources to those Black institutions, and doctors, and health care providers, so they can go into Black communities and engage in strategies that are going to be really effective."

Other disadvantaged populations have different problems. With indigenous people, "Invasion isn't an event, it's a structure," as were federal programs for "relocation, reservation, assimilation, termination," said Margaret P. Moss, PhD, JD, RN, Hidatsa/Dakhóta, Director of the First Nations House of Learning and an Associate Professor at the University of British Columbia School of Nursing.

For American Indians and Alaskan Natives, trusted, culturally relevant communication comes from the voices of community elders. But, in a situation made worse by the COVID-19 pandemic, the social determinants of health have led to low life expectancy and fewer people to carry that message. Only 9% of the American Indian Native Alaskan population is 65 or older compared to 16.5% of the general population, according to the U.S. Census.

"If they're the ones who are going to help make it OK, then we're really in trouble again," Dr. Moss said.

Strategic messaging needed

While noting that she is ready to take the vaccine, AMA Chief Health Equity Officer Aletha Maybank, MD, MPH, emphasized that strategic messaging is what's needed to overcome mistrust that has developed because "well-documented harms both in stories that have been passed down across generations and in the present lived experience." ✚

Oregon Health Authority

The Oregon Health Authority's COVID-19 Vaccine Advisory Committee aims to ensure the Oregon vaccine sequencing plan focuses on health equity and the needs of systemically affected populations, including communities of color, tribal communities and people with intellectual and developmental disabilities. For more information on the Committee's work, visit **covidvaccine.oregon.gov**. ✚

Reporting Requirements Q&A

The Oregon Medical Board often receives questions regarding the specifics of reporting requirements. Please see below for answers to some of the most common inquiries. ✚

This is part three in a three-part series of articles about reporting requirements. Previous editions of this newsletter covered what must be reported to the Board and what must be reported to other agencies. More information is available on the Board's website.

What if my colleague, a licensed health care professional, consults with me about an issue that turns out to be reportable conduct?

Oregon law does not allow any exception for consultation, group discussions, or colleague consultation. It is best practice to remind the other licensed professional of your mandatory reporting requirements under Oregon law and encourage them to self-report as well.

Do I report workplace impairment when the licensee says they will self-report? What if another colleague or the facility says they will report?

All licensees have a duty to report workplace impairment and should not rely on the possibility that a report will be made by another person or facility.

Do I report workplace impairment if I know the impaired person is participating the Health Professionals' Services Program (HPSP)?

All licensees are required to report workplace impairment under Oregon law, even if the impaired person is enrolled or intends to enroll in HPSP.

If my colleague, a Board licensee, tells me they are being admitted into an alcohol rehabilitation program but there was no indication of alcohol use or impairment while practicing medicine, do either of us need to report to the Board?

If there has been no impairment in the licensee's practice, and the licensee is actively seeking treatment, there is no mandatory reporting requirement. The Board encourages licensees to seek treatment before it impacts their ability to practice.

What if the other health care professional is my patient in a psychotherapist-patient relationship?

You must obtain consent to report violations learned of in the course of confidential patient communications. For full details, see the psychotherapist-patient privilege in ORS 40.230 and ORS 40.252.

Do I have to report if I allow my hospital/facility privileges to "lapse" or "not renew"?

If this happens while you are under investigation for any reason related to possible medical incompetence, unprofessional conduct, or physical incapacity or impairment, a report is required, even if you voluntarily allowed your privileges to lapse or expire.

What is an official action that has to be reported?

An official action is a restriction, limitation, loss, or denial of a licensee's privileges to practice medicine, or any formal action taken against a licensee by a government agency or a health care facility based on a finding of medical incompetence, unprofessional conduct, physical incapacity, or impairment. This includes reporting official actions from any state agency or other licensing board, such as the Oregon Health Authority or the Oregon Department of Human Services.

Do administrative suspensions for failure to maintain or complete records need to be reported?

Official actions do not include administrative suspensions of seven or fewer calendar days for failure to maintain or complete records. However, these short suspensions must be reported as an official action when the suspensions occur more than three times in any 12-month period as provided in OAR 847-010-0073(5).

What is unprofessional conduct?

Unprofessional conduct is conduct unbecoming a licensee or detrimental to the best interests of the public, including conduct contrary to recognized standards of ethics of the licensee's profession or conduct that endangers the health, safety, or welfare of a patient or client. Unprofessional conduct is further defined in ORS 677.188 and OAR 847-010-0073.

What are the potential consequences for reporting?

Mandatory reports are confidential under Oregon law. You must report if you have a reasonable belief that the conduct occurred; you need not be certain. Mandatory reporters are not liable for making a report in good faith. However, failure to report the prohibited or unprofessional conduct of another health care professional is a Class A violation and subjects the person to board discipline. Failure to self-report criminal conduct as required may result in board discipline.

Mandatory reporting requirements are generally in ORS 677.092, ORS 677.415, and 676.150.

More questions? Send an email to info@omb.oregon.gov. ✚

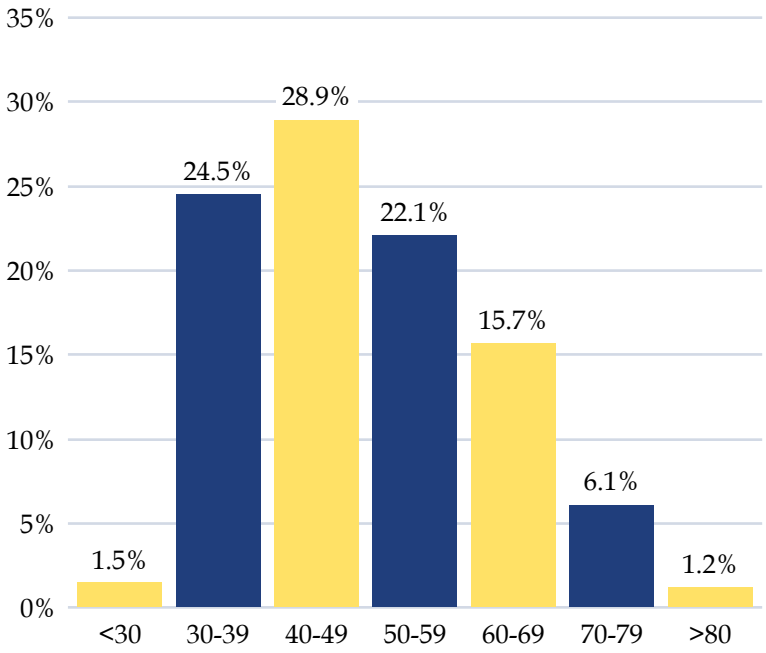
Annual Licensing Statistics

As of December 31, 2020, the OMB had a total of 23,946 licensees. Of that number, 21,590 held active* licenses to practice in Oregon. Another 888 individuals held limited licenses of various kinds. ✚

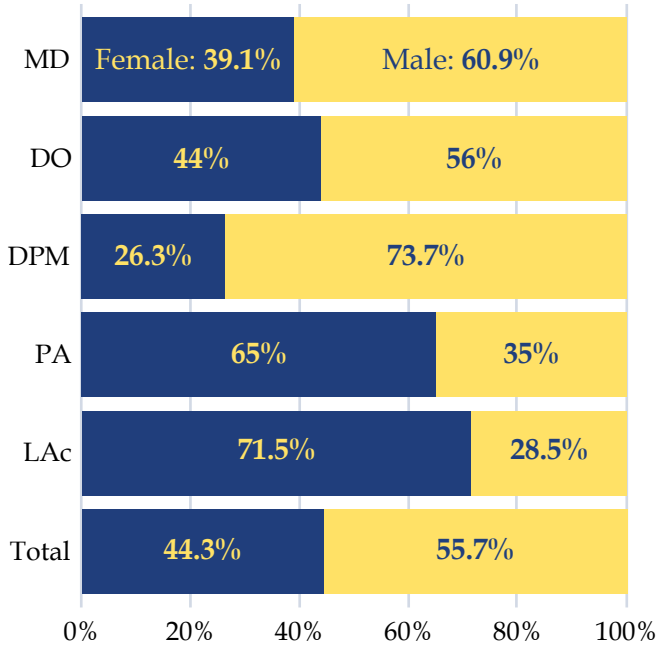
Status	Doctors of Medicine (MD)	Doctors of Osteopathic Medicine (DO)	Podiatric Physicians (DPM)	Physician Assistants (PA)	Acupuncturists (LAc)
Active	15,687	1,758	220	2,394	1,531
Inactive	1,167	115	4	124	58
Limited *(all types)*	702	174	12	0	0
Total	17,556	2,047	236	2,518	1,589

**Active licenses include: Active, Emeritus, Locum Tenens, Military/Public Health, Telemedicine, Telemonitoring, Teleradiology, Administrative Medicine, and Volunteer Emeritus*

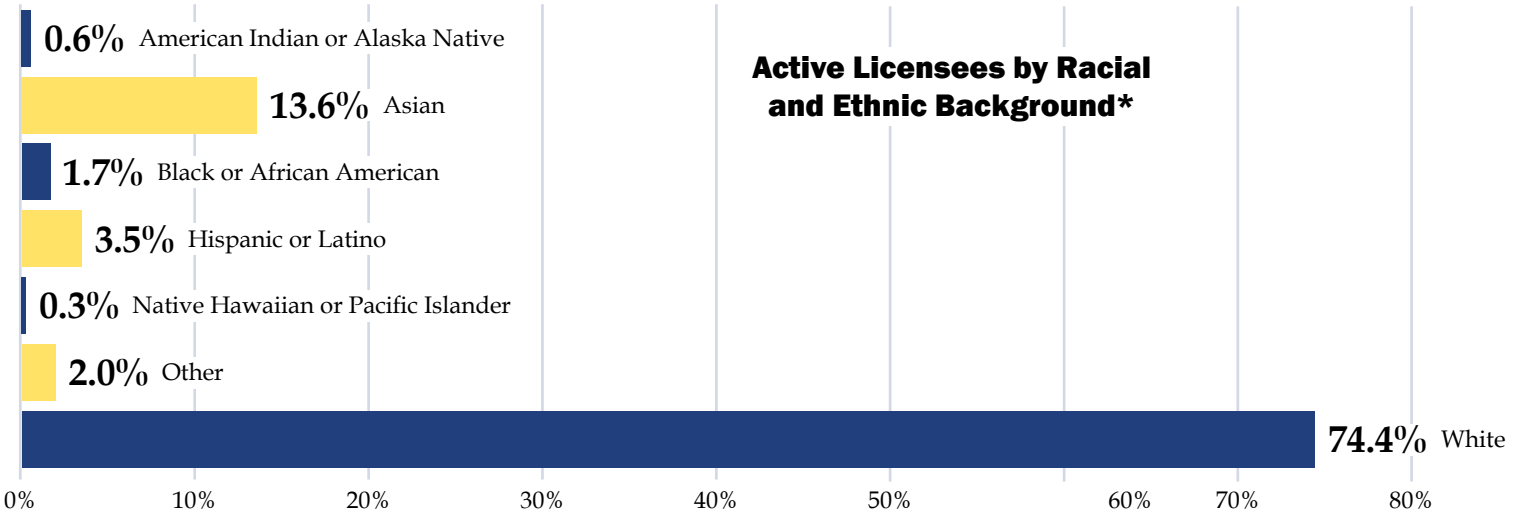
Active Licensees by Age



Active Licensees by Gender



Active Licensees by Racial and Ethnic Background*



**Approximately 4% of Oregon licensees did not specify their racial and ethnic background.*

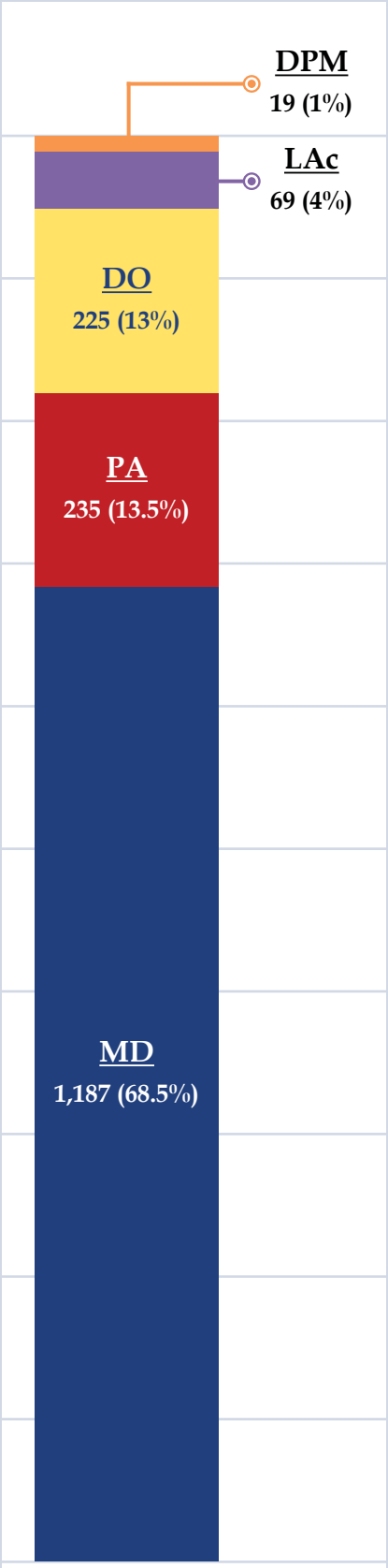
Licensees by County

The data below reflects current practice addresses reported by licensees who have full licenses at practicing status. If a licensee provides practice addresses in more than one county, the licensee will be counted in each county. Therefore, the data does not represent full-time clinical practitioners in each county. ✚

County (Seat)	MD	DO	DPM	PA	LAc	Total	Population
Baker (Baker City)	79	10	2	15	2	108	16,910
Benton (Corvallis)	317	109	5	85	22	538	94,665
Clackamas (Oregon City)	1,223	152	23	183	118	1,699	426,515
Clatsop (Astoria)	131	12	5	22	12	182	39,455
Columbia (St. Helens)	27	5	0	18	7	57	53,280
Coos (Coquille)	168	22	3	26	7	226	63,315
Crook (Prineville)	24	6	0	10	1	41	23,440
Curry (Gold Beach)	62	7	2	9	5	85	23,005
Deschutes (Bend)	694	94	10	199	83	1,080	197,015
Douglas (Roseburg)	228	47	7	60	7	349	112,530
Gilliam (Condon)	1	0	0	1	0	2	1,990
Grant (Canyon City)	16	4	1	0	1	22	7,315
Harney (Burns)	17	7	0	1	0	25	7,280
Hood River (Hood River)	120	7	2	20	17	166	25,640
Jackson (Medford)	728	94	13	150	68	1,053	223,240
Jefferson (Madras)	33	1	0	17	0	51	24,105
Josephine (Grants Pass)	154	33	6	52	19	264	86,560
Klamath (Klamath Falls)	167	14	2	39	7	229	68,075
Lake (Lakeview)	11	2	0	2	0	15	8,075
Lane (Eugene)	1,052	94	15	235	86	1,482	381,365
Lincoln (Newport)	100	28	3	34	11	176	48,305
Linn (Albany)	187	53	4	58	8	310	127,320
Malheur (Vale)	137	25	1	39	0	202	32,105
Marion (Salem)	902	121	19	173	48	1,263	349,120
Morrow (Heppner)	7	1	0	9	0	17	12,825
Multnomah (Portland)	5,008	396	49	723	759	6,935	829,560
Polk (Dallas)	67	23	1	27	4	122	83,805
Sherman (Moro)	3	0	0	2	0	5	1,795
Tillamook (Tillamook)	60	9	2	13	7	91	26,530
Umatilla (Pendleton)	248	34	4	30	2	318	81,495
Union (La Grande)	60	18	3	3	6	90	26,840
Wallowa (Enterprise)	20	1	1	2	7	31	7,160
Wasco (The Dalles)	97	11	2	14	11	135	27,295
Washington (Hillsboro)	1,967	152	34	368	157	2,678	620,080
Wheeler (Fossil)	2	0	0	2	0	4	1,440
Yamhill (McMinnville)	198	28	6	38	16	286	108,605

Source: sos.oregon.gov/blue-book/Pages/local/county-population.aspx

New Licensees



The OMB welcomed **1,735** new licensees in 2020. ✚

Annual Investigative Statistics

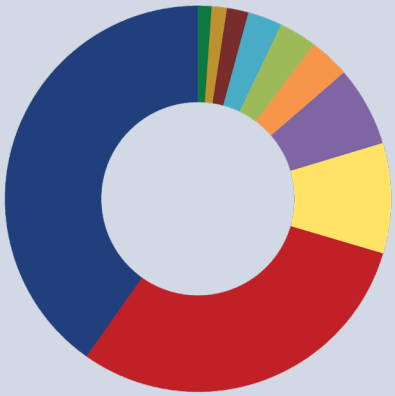
OMB Staff is continually preparing for and wrapping up Board and Committee meetings. In 2020, the Investigative Committee met eight times. Each quarterly Board meeting requires Board members to read, and staff to compile, over 10,000 pages of material. The following statistical reports are a snapshot of the resulting work. ✚

	Final Dispositions of Investigations	2018	2019	2020
No Violations	Exceptionally Closed	8	7	10
	No Apparent Violation	322	348	298
	Preliminary Investigation	116	111	90
	Prior to Committee Appearance	84	107	97
	Post Committee Appearance	0	2	2
	Letter of Concern/Prior to Committee Appearance	106	136	149
	Letter of Concern/Post Committee Appearance	12	16	12
	After Staff Inquiry	0	1	1
	Executive Staff Review of HPSP N/C	0	2	8
	No Violation/App Withdrawal w/ Report to Federation	5	2	0
	Temporarily Closed without Board Order	1	0	0

Investigation Totals	2018	219	2020
Investigations Opened	819	842	750
Investigations Closed	732	815	768
Investigative Committee Interviews	47	50	61
Reportable Orders	51	56	80

Public Orders & Agreements	2018	219	2020
Automatic Suspensions	0	1	1
Consent Agreements	14	23	16
Corrective Action Agreements	9	8	13
Stipulated Orders	39	46	62
Voluntary Limitations	0	1	0
Final Orders	3	4	8

Source of Investigations	2018	2019	2020
Oregon Medical Board	93	106	96
Board or HPSP Non-Compliance	5	3	6
Co-worker/Other Staff	10	2	10
Hospital or Other Health Care Institution	33	25	26
Insurance Company	2	0	0
Malpractice Review	23	63	44
HPSP/Monitoring Entity	25	35	25
Other	83	56	64
Other Boards	11	3	4
Other Health Care Providers	65	70	50
Patient or Patient Associate	449	455	413
Pharmacy	3	4	3
Self-Reported	22	27	23



Categories of Complaints:

- Impairment - 1%
- Substance Abuse - 1%
- Sexual Misconduct - 2%
- Board Compliance - 3%
- Failure to Report - 3%
- Malpractice Review - 3%
- Inappropriate Prescribing - 7%
- Other/Misc. - 9%
- Inappropriate Care - 30%
- Unprofessional Conduct - 40%

Topic of Interest: Telemedicine

The practice of medicine occurs at the patient's location when technology is used to provide care. The provider must possess appropriate licensure in all jurisdictions where the patient receives care. **Providers practicing via telemedicine on patients located in Oregon must be licensed in Oregon.** *

Oregon Medical Board licensees intending to practice via telemedicine on patients outside of Oregon (including patients located in Washington) must check with the other state's licensing board.

When practicing via telemedicine, the licensee is expected to maintain an appropriate provider-patient relationship and is held to the same standard of care. The Board does not require an in-person visit to establish or maintain the provider-patient relationship; however, some situations and presentations are appropriate to provide care via telemedicine, while some are not.

More information is available on the **Telemedicine Topic of Interest webpage**, including information by type of license and illustrative examples. The Board's **Statement of Philosophy on Telemedicine** provides guidance for practicing via telemedicine.

Questions? Send an email to **info@omb.oregon.gov**.

The Board's website is a resource for a wide range of other topics, including wellness and patient records. To learn more, visit **omb.oregon.gov/topics**. ✚

** Various exceptions exist in ORS 677.060. In addition, on December 3, 2020, the U.S. Department of Health and Human Services issued a **4th amendment** to the PREP Act to increase access to critical countermeasures against COVID-19, see the amendment for details.*

Topic of Interest: REALD Data Collecting and Reporting Requirements

In June 2020, the Oregon State Legislature passed House Bill 4212 requiring licensees of the Oregon Medial Board to collect race, ethnicity, language, and disability (REALD) data from patients during a COVID-19 encounter.

Communities of color and disabled communities are disproportionally impacted by COVID-19. Without the collection and reporting of REALD data for COVID-19 encounters, these inequities cannot be adequately tracked and measured, and the state's response to mitigating the spread and health impacts of COVID-19 for the purpose of service provision will continue to be impaired. REALD data is a critical building block to eliminate health inequities in order to achieve full health equity and rectify the root causes related to racism, discrimination, and oppression.

REALD data collected during a COVID-19 encounter must be reported to the Oregon Health Authority (OHA) in accordance with the state's disease reporting rules. A COVID-19 encounter is an interaction between a patient or the patient's legal representative and a health care provider, whether that interaction is in person or through telemedicine, for the purpose of providing health care services related to COVID-19, including but not limited to ordering or performing a COVID-19 test. More information and specific requirements for disease reporting and appropriate timelines can be found in **OAR 333-018-0011** and **333-018-0016**, or the state's **Disease Reporting website**.

This standardized data collection methodology will improve the ability of the OHA, Oregon Department of Human Services, providers, and decision makers to recognize, address, target, and eliminate inequities experienced by distinct racial, cultural, and linguistic communities, and by people with disabilities. The standards for collecting REALD information can be found at **OAR 943, Division 70**.

Implantation of REALD data collection is being phased over a 12-month period. On October 1, 2020, hospitals and health care providers within a health system started reporting, and by October 1, 2021, all health care providers will be required to report.

OHA will report non-compliant licensees to the Board. The Board will work to bring health care providers into compliance, but the collection and reporting of REALD information is a priority for the state and will be taken seriously.

More information is available on the Oregon Health Authority's **REALD webpage** and the Board's **REALD Data Collecting and Reporting Requirements Topic of Interest webpage**. ✚

Vaccine Cognitive Biases, continued

3) Address cognitive bias. Helping a patient see their own cognitive bias can be tricky, and more of an art than a science, but it is doable and becomes more successful the more you practice. The example of the flu vaccine is a good starting point. Once they see it's possible for them to prefer things that are actually worse for them, the door opens to discussion about science. There are several other cognitive biases worth reading about, starting with "negativity bias." In brief, anytime something goes wrong in life, we look back for things to blame it on. But when things go right, we don't do this.

4) Tailor your approach to their specific goals or worries. Focus on something specific they're worried about, like autoimmune disease. They might not care about risk of death, but more concerned with maintaining a natural state of health while they're alive. If so, talk about how vaccines are a natural alternative to antibiotic consumption (protecting the gut flora), avoid hospitalizations, and substantially reduce complications from disease (like sterility from mumps, immune amnesia from measles, brain damage from Hib, etc).

5) Continue to provide excellent care for patients who skip or delay shots. Some physicians find this hard, but it's important. Kicking them out increases under-vaccinated clusters in our communities, which is how outbreaks start. And treating them worse only confirms their bias. Treating them well challenges their bias and provides an opportunity for them to come around in the future, which you lose if you sever or damage that relationship. While some claim that seeing under-vaccinated patients is an increased risk to your staff or other patients, this is not true. Having under-vaccinated people in your community is the biggest risk: they may shop where you shop, their kids may go to school with your kids. Your clinic is the most infection-controlled environment you share with them. Anything you can do to increase your community's vaccination rate will protect your patients and your staff the most.

I've been able to profoundly impact most families in the short time we have available during visits, though others have needed more extensive information. To this end, I helped found a nonprofit organization called Boost Oregon in 2015 to help with that scenario. We hold community workshops where people can come and learn about vaccines and cognitive bias, and these have been extremely successful. We produce parents' and providers' guides that can help you be more successful in your practice with vaccine communication. We also offer COVID-19 vaccine workshops for patients and seminars for providers. More information at **boostoregon.org** or email **info@boostoregon.org**.

Most people who are hesitant to receive a vaccine are not out there creating anti-vaccine rhetoric. They don't want anyone to come to harm. They are victims of cognitive bias and don't realize it. They are also victims of misinformation, and they are hesitant because they're afraid. If you help them identify where their fear comes from, then help them identify false information, chances are they will be grateful to have that fear lifted. Usually, patients will choose to follow the recommended schedule. A small number may still skip a shot or two. But our community's vaccination rates will be substantially higher, the most important marker of disease prevention. Lastly, relationships with hesitant patients will be more fulfilling as you may find more common ground and shared goals than previously thought. ✚

Oregon Administrative Rules

Rules proposed and adopted by the Oregon Medical Board.

The Oregon Medical Board and other state agencies operate under a system of administrative rules to ensure fairness and consistency in procedures and decisions. Periodically, these Oregon Administrative Rules (OARs) must be amended in response to evolving standards and circumstances. OARs are written and amended within the agency's statutory authority granted by the Legislature.

Rules go through a First and Final Review before being permanently adopted. Temporary rules expire 180 days after adoption unless permanently adopted through the rulemaking process. Official notice of rulemaking is provided in the Secretary of State Bulletin. The full text of the OARs under review and the procedure for submitting comments can be found at **omb.oregon.gov/rules**.

PROPOSED RULES

*First Review. Written comments accepted as provided for each rule via email to **elizabeth.ross@omb.oregon.gov**.*

847-010-0068: Practice in Oregon in the Event of an Emergency

The proposed rule makes permanent the temporary rule to reiterate and clarify that during a declared emergency all board licensees are expected, in connection with the practice of medicine, to fully comply with Executive Orders and statewide guidance implementing the Executive Orders when the Order or guidance documents in whole or in part address or affect the delivery of health care to Oregon patients.

847-035-0030: EMS Scope of Practice for Cardiac Monitoring and Electrocardiogram

The proposed amendment updates the scope of practice for emergency medical services providers to allow Emergency Medical Technicians (EMT) and higher to acquire and transmit cardiac monitoring and electrocardiogram (ECG) and for Paramedics to interpret ECG. The rule is needed to clarify the scope of practice regarding cardiac monitoring and ECG as technology evolves. The amendment will be particularly helpful in rural areas of the state.

ADOPTED RULES

847-008-0077, 847-008-0070: Mandatory Cultural Competency Education

The rule implements changes to ORS 676.850 provided in HB 2011 (2019) mandating cultural competency education as a condition of license renewal. The rule requires Board licensees to complete the equivalent of at least one hour of cultural competency continuing education per year. Hours could be obtained at any time during the audit period and licensees may report hours every license registration renewal cycle, but compliance audits would be done every other cycle. During the license registration renewal, licensees will attest to completing the required hours and report the number of completed hours. The Board will start auditing during the Fall 2023 renewal cycle.

TEMPORARY RULES

847-010-0068: Practice in Oregon in the Event of an Emergency

The Board adopted a temporary rule to reiterate and clarify that during a declared emergency all board licensees are expected, in connection with the practice of medicine, to fully comply with Executive Orders and statewide guidance implementing the Executive Orders when the Order or guidance documents in whole or in part address or affect the delivery of health care to Oregon patients. The temporary rule is valid from December 10, 2020, through June 6, 2021.

Board Actions

October 16, 2020 - January 15, 2021

Many licensees have similar names. When reviewing Board Action details, please review the record carefully to ensure that it is the intended licensee.

EMERGENCY SUSPENSIONS

LATULIPPE, Steven A., MD; MD22341
Dallas, OR

At 5:15 p.m., on December 3, 2020, the Board voted to issue an Order of Emergency Suspension to immediately suspend Licensee's medical license due to the Board's concern for the safety and welfare of Licensee's current and future patients. This Order is in effect until otherwise ordered by the Board.

THOMAS, Paul N., MD; MD15689
Portland, OR

At 5:15 p.m., on December 3, 2020, the Board voted to issue an Order of Emergency Suspension to immediately suspend Licensee's medical license due to the Board's concern for the safety and welfare of Licensee's current and future patients. This Order is in effect until otherwise ordered by the Board.

INTERIM STIPULATED ORDERS

*These actions are not disciplinary because they are not final orders, but are reportable to the national data banks.**

BAILEY, Douglas D., MD; MD14262
Junction City, OR

On December 18, 2020, Licensee entered into an Interim Stipulated Order to voluntarily cease the prescribing or refilling of any prescriptions for controlled substances pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

JOHNSON, Cory T., MD; MD24075
Klamath Falls, OR

On December 3, 2020, Licensee entered into an Interim Stipulated Order to voluntarily withdraw from practice and place his license in Inactive status pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

MAJOR, Jonathan M., LAc; AC155574
Jacksonville, OR

On October 30, 2020, Licensee entered into an Interim Stipulated Order to voluntarily withdraw from practice and place his license in Inactive status pending the completion of the Board's investigation into his ability to safely and competently practice acupuncture.

REYES, Vincent P., MD; MD16883
Hillsboro, OR

On December 29, 2020, Licensee entered into an Interim Stipulated Order to voluntarily cease performing femoral access for any procedure, any interventional cardiology procedure, or rotational atherectomies; and have a pre-approved, board-certified cardiologist serve as co-proceduralist for any pacemaker procedures pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

ROSEN, Ronald D., MD; MD17449
Bend, OR

On November 25, 2020, Licensee entered into an Interim Stipulated Order in which he will voluntarily cease all clinical encounters on November 30, 2020, and withdraw from practice on December 14, 2020, and place his license in Inactive status pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

NON-DISCIPLINARY BOARD ACTIONS

*These actions are not disciplinary and are not reportable to the national data banks.**

CORRECTIVE ACTION AGREEMENTS

These agreements are not disciplinary orders and are not reportable to the national data banks unless they relate to the delivery of health care services or contain a negative finding of fact or conclusion of law. They are public agreements with the goal of remediating problems in the Licensees' individual practices.*

AUSTIN, Douglas J., MD; MD20456
Eugene, OR

On January 7, 2021, Licensee entered into a non-disciplinary Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete the OHSU ECHO Certificate Program; complete the New England Journal of Medicine Pain Management and Opioids CME; submit clinic policies regarding management of chronic pain patients to the Board's Medical Director for approval; and follow the Oregon Health Authority's Pregnancy and Opioids Workgroup Recommendations.

GARDNER, Marion L., Jr., MD; MD17617
North Plains, OR

On January 7, 2021, Licensee entered into a non-disciplinary Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to contract with CPEP for the development of an education plan; complete the CPEP education plan; and be subject to no-notice chart audits and office visits.

KRISHNAMURTHY, Priya, MD; MD150865
Tualatin, OR

On January 7, 2021, Licensee entered into a non-disciplinary Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete a pre-approved course in patient communications; contract with a pre-approved practice management consultant to assess the operational policies and procedures of Licensee's medical practice and formulate an improvement plan, or hire a pre-approved practice management firm to manage all operations at Licensee's practice; complete a pre-approved course in practice management if Licensee should no longer own and operate her own practice; and maintain an on-going therapeutic relationship with a pre-approved healthcare provider.

PATTERSON, Emma J., MD; MD22571
Portland, OR

On January 7, 2021, Licensee entered into a non-disciplinary Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete pre-approved courses in anger management and communications.

CONSENT AGREEMENTS FOR RE-ENTRY TO PRACTICE

*These actions are not disciplinary and are not reportable to the national data banks.**

LOPEZ, Carl E., MD; MD13942
Hermiston, OR

On December 2, 2020, Licensee entered into a non-disciplinary Consent Agreement for Re-Entry to Practice with the Board. In this Agreement, Licensee agreed to practice under the supervision of a pre-approved physician mentor for 500 hours.

MADARANG, Elizabeth, MD; MD184006
Beaverton, OR

On November 30, 2020, Licensee entered into a non-disciplinary Consent Agreement for Re-Entry to Practice with the Board. In this Agreement, Licensee agreed to practice under the supervision of a pre-approved physician mentor for 500 hours, to include reports to the Board by the mentor.

RUTH, Amy, MD; MD21564
Portland, OR

On November 23, 2020, Licensee entered into a non-disciplinary Consent Agreement for Re-Entry to Practice with the Board. In this Agreement, Licensee agreed to practice under the supervision of a pre-approved physician mentor for 1,000 hours, to include reports to the Board by the mentor.

SHIH, Betty P., MD; SX202809
Milwaukie, OR

On November 5, 2020, Applicant entered into a non-disciplinary Consent Agreement for Re-Entry to Practice with the Board. In this Agreement, Applicant agreed to practice under the supervision of a pre-approved physician mentor for 1,000 hours, to include reports to the Board by the mentor; and pass the Special Purpose Examination within six months.

TREADWELL, Amalia B.O., LAc; AC159603
Portland, OR

On December 29, 2020, Licensee entered into a non-disciplinary Consent Agreement for Re-Entry to Practice with the Board. In this Agreement, Licensee agreed to complete an 80-hour mentorship with a Board-approved clinical supervisor.

DISCIPLINARY ACTIONS

*These actions are reportable to the national data banks.**

ARMSTRONG, Andrew, MD; PG200540
Portland, OR

On January 7, 2021, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; impairment; fraud or misrepresentation in applying for or procuring a license to practice medicine in this state; and willful violation of any rule adopted by the Board. This Order reprimands Licensee; requires Licensee to remain enrolled and in good standing in a monitoring program; and requires Licensee to maintain a relationship with Board-approved healthcare providers.

CARLSON, Jessica R., MD; MD176604
Gold Beach, OR

On January 7, 2021, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct and gross or repeated acts of negligence. This Order prohibits Licensee from performing breast reconstruction surgery without a Board approved board-certified plastic surgeon in attendance; and requires Licensee to complete courses on the management of breast disease and a documentation course.

GAEKWAD, Satyajeet Y., MD; MD26995
Chillicothe, MO

On January 7, 2021, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct and repeated acts of negligence. With this Order, Licensee surrenders his Oregon medical license while under investigation.

HAPUTA, Andrew J., MD; MD190539
Stayton, OR

On January 7, 2021, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; impairment; and willful violation of a Board rule. This Order reprimands Licensee; requires Licensee to remain enrolled and in good standing in a monitoring program; and assesses a $500 civil penalty.

HEITSCH, Richard C., MD; MD11610
Portland, OR

On January 7, 2021, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct and gross or repeated acts of negligence. This Order prohibits Licensee from treating any patient with hyperbaric oxygen or performing hyperbaric oxygen therapy; and requires Licensee to complete a Board-approved documentation course.

HU, Chester C., MD; MD166528
Gresham, OR

On January 7, 2021, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; gross or repeated acts of negligence; and disciplinary action by another state. This Order reprimands Licensee; assesses a $5,000 civil penalty; places Licensee on probation; requires Licensee to follow published guidelines for monitoring and managing pediatric patients before, during, and after sedation procedures in the dental setting; requires Licensee to follow terms of his Washington Order regarding following a pre-anesthesia procedure, implementing a checklist for use with pediatric patients, following a recovery procedure, and ensuring all support personnel involved in the perioperative anesthesia period of a pediatric case conform to certain standards of care; and subjects Licensee's practice to no-notice chart audits and office visits. Terms imposing probation and practice requirements will be held in abeyance as long as Licensee's Oregon license remains at a non-practicing status.

HUBBS, Aaron W., LAc; AC01137
Portland, OR

On January 7, 2021, Licensee entered into a Stipulated Order with the Board for unprofessional conduct and willful violation a Board rule or order. This Order reprimands Licensee and requires Licensee to only practice at sites that are pre-approved by the Board's Medical Director.

KEIPER, Glenn L., Jr., MD; MD20444
Eugene, OR

On January 7, 2021, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; fraud or misrepresentation in applying for or procuring a license to practice in this state; willful violation of any provision of the Medical Practice Act; and failure to report any adverse action by a court. This Order reprimands Licensee; assesses a $5,000 civil penalty with $2,500 held in abeyance; and requires Licensee to complete pre-approved courses on professional boundaries and ethics, documentation, and communications.

MELNICK, Jeffrey B., PA; PA00251
Wilsonville, OR

On January 7, 2021, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct and gross or repeated acts of negligence. With this Order, Licensee surrenders his physician assistant license while under investigation.

MELVIN, Kenneth P., MD; MD24232
Lake Oswego, OR

On January 7, 2021, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct. With this Order, Licensee surrenders his medical license while under investigation.

METZGER, Chris A., MD; MD28806
Bend, OR

On January 7, 2021, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; fraud or misrepresentation in applying for or procuring a license to practice in this state; violation of a rule adopted by the Board; and failure to self-report any official action to the Board. This Order assesses a $2,000 civil penalty.

SCHMIDT, Linda E., MD; MD24604
Portland, OR

On January 7, 2021, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct and impairment. This Order reprimands Licensee and requires Licensee to remain enrolled and in good standing in a monitoring program.

SHARMA, Bhanoo, MD; MD150955
Hazel Crest, IL

On January 7, 2021, Licensee entered into a Stipulated Order with the Board for any conduct or practice which does or might constitute a danger to the health or safety of a patient or the public; willful performance of any surgical or medical treatment which is contrary to acceptable medical standards; administration of unnecessary treatment and utilizing medical service for diagnosis or treatment which is or may be considered inappropriate or unnecessary; and gross or repeated acts of negligence. With this Order, Licensee surrenders his medical license while under investigation.

VOGT, Amber J., DO; DO179860
Clackamas, OR

On January 7, 2021, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct and impairment. This Order reprimands Licensee, and requires Licensee to remain enrolled and in good standing in a monitoring program.

ZAMORA, Joanna M., MD; MD173312
Portland, OR

On January 7, 2021, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct and impersonating another licensee or permitting or allowing any person to use Licensee's license. This Order reprimands Licensee and requires Licensee to remain enrolled and in good standing in a monitoring program.

PRIOR ORDERS MODIFIED OR TERMINATED

STICKER, Carol L., PA; PA194156
Portland, OR

On January 12, 2021, the Board issued an Order Modifying Consent Agreement for Re-Entry to Practice. This Order modifies Licensee's July 30, 2019, Consent Agreement for Re-Entry to Practice.

Current and past public Board Orders are available on the OMB website.

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Oregon Medical Board
1500 SW 1st Ave, Suite 620
Portland, OR 97201
971-673-2700
info@omb.oregon.gov
www.oregon.gov/OMB

Office Hours

Monday - Friday, 8 a.m. - 5 p.m.
(closed 12 p.m. - 1 p.m.)

Office Closures

Notice: OMB staff are available by phone and email; however, the OMB offices are currently closed to the public. Please contact OMB staff at 971-673-2700 or info@omb.oregon.gov. Questions about COVID-19? Visit omb.oregon.gov/COVID-19.

Monday, Feb. 15 - **Presidents Day**

Monday, May 31 - **Memorial Day**

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For new license applications, renewals, address updates, practice agreements, and supervising physician applications: omb.oregon.gov/login

Licensing Call Center

Hours: 8 a.m. - 3 p.m.
Phone: 971-673-2700
Email: licensing@omb.oregon.gov

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Statement of Purpose

*The **OMB Report** is published to help promote medical excellence by providing current information about laws and issues affecting medical licensure and practice in Oregon.*